Culturally Competent Care in the Emergency Medical Services

Lynne Dees, MFA, LP, NREMT-P

When two paramedics and an EMT-B responded to a dispatch for an unconscious child, they found a two-year-old who was reported by his father to have collapsed while standing in the bed of the family truck with the man's father and brother. A neighbor translated information to the EMS crew because the Spanish-speaking parents were too distraught to speak English. The ambulance crew gathered information about the event, treated and transported the child to the pediatric trauma center. The child subsequently died after surviving on life support for three days.

Distraught over their son's death, the parents hired an attorney and filed a lawsuit. The father claimed that the EMS crew spent too much time on the scene to question the parents because they suspected child abuse. He stated that the rescuers saw that he and his family were Hispanic, acted in a discriminatory manner, and as a result did not provide appropriate patient care. Later the father stated to a newspaper reporter that he wanted the responders to treat him like a brother, but instead they treated his family like animals. The child was later found to have suffered a ruptured congenital brain aneurysm which, according to the attending physician, would have killed him even if it had occurred while he was in the emergency room. Although the medics were found to have acted appropriately, the family and city settled out of court for $93,000, and all fire department personnel now undergo mandatory cultural sensitivity training.

In the United States, the population majority is shifting toward a diverse mix of individuals from various cultures, ethnicities, races and faiths. The U.S. Census projections place Latinos as the largest minority group with 24.4 percent of the population by 2050, followed by African-Americans (14.6 percent), and Asians (8.0 percent) (United States Census Bureau, 2004). By mid-century, Caucasian European descendants will begin to constitute a population minority (Ikeda and Wright, 1998). In 2005, Texas became the fifth state with a majority of the population (50.2%) comprised of minority groups (United States Census Bureau, 2005), including 7.8 million Hispanics, 2.7 million African-Americans, 0.8 million Asians, 0.4 Pacific Islanders and Native Hawaiians, and 0.25 million Native Americans. As the minority population numbers have escalated, the variety of ethnicities and cultures has also increased. Newer immigrants are arriving from Korea, Central America, India, Pakistan (Frey, 1999) and other areas.

Several factors have contributed to the growth of the minority population in the U.S., including immigration, facilitated and increased international travel, high minority fertility rates and a decrease in Caucasian fertility rates (Juckett, 2005). Texas,

along with the rest of the country, is experiencing minority growth from the influx of immigrants arriving from mainstream areas (Mexico) and non-mainstream areas such as the Middle East. The ethnic mix in Dallas and Houston has become quite diverse, while other metropolitan areas such as El Paso and San Antonio have large and growing Hispanic communities. EMS personnel in Texas respond to a large number of patients from a variety of cultures. Although cultural competency is not a simple skill or a set of do's and don'ts that can be learned overnight, several points may guide EMS personnel toward a better understanding of their patients.

Culture may be defined as the learned and shared beliefs, behaviors and attitudes by members of a group (Galanti, 2004). Groups are defined geographically, by profession, age, faith, values, ethnicity, race or heritage. Even EMS and other rescue personnel have a unique culture of their own. Each time rescuers respond to a call and walk into a patient's life, they are confronted with elements of the patient's culture, which play a considerable role in communication and medical care provided to the patient.

All members of a group do not assimilate their culture equally. The EMS provider should address patients, their family and bystanders on an individual basis rather than assuming all members share the same viewpoint. For example, all African-Americans do not eat "soul" food, and not all Latinos practice the Catholic faith or have large families. Not all Caucasians are uptight or dance without rhythm. People from a particular ethnic group or culture should not be pigeonholed, which leads to stereotyping. In the United States, most groups do not live in an isolated environment, but are instead influenced by many other factors. Culture is defined and shaped by multiple variables such as religion, politics, education, place of origin and socioeconomic status. To complicate matters further, some individuals adhere to more than one culture or experience acculturation (adapting or borrowing mainstream practices from another culture).

An individual's culture has a direct effect upon health beliefs, values and practices. Culture also shapes our patients' confidence in and viewpoint of modern medicine and healthcare professionals. It also colors their self-assessment regarding the severity of their own ailments and willingness to take medicine or follow a diet or exercise regime. Most individuals who call 9-1-1 for medical care know what to expect and that they will be treated with principles of modern medicine. However, for some, EMS is called as a last resort, which may not only represent their sole contact with mainstream medicine, but also may conflict with their own belief system.

Beliefs regarding health, illness and healing vary among different cultures. Culture does not exist in a vacuum and depends upon the level of acculturation into the mainstream culture. While most American ethnic groups and minorities adhere to the traditions of preventive medicine such as visiting a physician when ill, taking prescribed medications when necessary, and calling EMS only for dire situations, some cultures follow a different set of practices. Many groups depend first upon their own resources within the family and community to maintain health and heal themselves when ill. The curandero (healer), sobador (massage therapist), herbalista (herbalist) and partera (midwife) in Spanish-speaking communities provide traditionally-accepted rituals and/or cures which may have been exhausted by the time EMS is summoned. Asian-American and Hispanic patients may practice hot-cold or other balancing therapy, and African-American and Native American cultures may rely upon prayer or offerings for healing.

Although most patients EMS providers contact are aware that pathogens, unhealthy lifestyles, and unsafe practices cause illness, some cultures may believe that illness results because of evil spirits, a perceived

injustice, lack of faith, immoral lifestyle, imbalances of the body and/or spirit (hot-cold or wet-dry), a great fright (susto), or a hex, curse, or envy (mal de ojo). Even if EMS personnel explain the medical cause of a condition with emphasis upon a good prognosis, the patient and/or his or her family may view it with great shame or embarrassment. In some cultures, cancer is considered a curse and a social stigma, and is kept secret from the community and even the patient (Thomas, Saleem, & Abraham, 2005). Members of other cultures may view illness as a personal family matter and resent the intrusion of EMS personnel, even if they themselves call 9-1-1 for help, which may seem perplexing and contradictory to the responding EMTs.

Unfortunately, the health status for minority groups in the United States is worse than for Anglos, even for those who possess sufficient health insurance (Institute of Medicine, 2002). Many individuals do not access health care regularly because of fear of deportation, lack of money, transportation, resources such as sick or vacation time and access to child care. Others mistrust the healthcare system, such as African-Americans who are keenly aware of past injustices. In the 1940s Tuskegee syphilis study in Alabama, physicians withheld syphilis treatment from African-American men in order to document the course of the disease to the men's deaths (Galanti, 2004). Many patients may refuse transport to a medical facility for similar reasons.

Individuals in some ethnic and religious groups such as African-Americans, Native Americans, Hispanics, Filipinos and Muslims may believe in fatalism and God's will, which deters them from seeking medical care for curable diseases and especially for cancer. Researcher Chen-Li Sung (1999) noted that Asian immigrants, who come from cultures with long traditions of herbalist or shamanistic healing, may not feel at a disadvantage if not seeking medical care from American physicians, or by not complying with prescribed medications, diets, medical tests and procedures, or attending follow-up doctor's appointments.

A language barrier prevents many individuals from accessing health care. More EMS personnel are making an effort to learn Spanish and the emergency services promote the hiring of Spanish-speaking providers. However, recent immigrants and those who live in tightly knit communities continue to experience an enormous language barrier when attempting to access health care.

In Asian populations medical personnel are highly respected. To disrespect or contradict them is a cultural taboo. This can create miscommunication when a patient who doesn't quite understand the EMT or paramedic merely nods affirmatively or states, "yes, yes." Such actions can be misconstrued that the patient understands that which is being told to him or that he has erroneously agreed to treatment. The distaste for contradicting authority figures may lead to the acquisition of inaccurate patient information or medical history when the EMT is interviewing and assessing the patient. Silence on the part of the non-English-speaking patient can be interpreted as open hostility by EMTs (Sung, 1999). Although often construed by EMS providers as manipulative, bilingual patients may revert to their language of origin in times of stress.

In many cultures, close-knit families such as the Roma (Gypsies) look after and take care of each other (Vivian & Dundes, 2004). One common source of consternation for EMTs regards the insistent answering of questions by family and bystanders when the EMT is attempting to establish level of consciousness by directly eliciting information from the patient. In a matriarchal culture such as some African groups, the oldest female may serve as the patient's spokesperson. Conversely, in a traditional patriarchal culture such as that which is seen in the Middle East, the EMT or paramedic may need to address the male

figurehead. However, in situations relating to 'women's problems,' that responsibility may be delegated to a female in the family or group. Personalismo, the establishing of personal relationships, is a concept essential in the Hispanic culture. Although utilized more in the clinical setting and less in the emergency setting, establishing confianza (trust) by acknowledging the patient's interests and/or family, especially the children, will increase cooperation by the Hispanic patient and family (Galanti, 2004).

The perception of space and time influences patients' communication with the EMTs and paramedics that respond to their call for help. Most patient-to-EMT contact occurs within a personal and intimate distance of four feet. Whereas middle class Anglo culture views such close proximity appropriate for patient care, similar close contact by family and bystanders may prove uncomfortable to the EMT or paramedic, yet may be the norm for other cultures.

Cultural mores of modesty practiced by traditional Muslim women may provide a conflict because touch and examination by an EMS provider of the opposite gender may be considered inappropriate. Cultural modesty deters many from seeking medical care in the first place; however, ambulance personnel may encounter such patients in vehicle accidents or catastrophic events.

Different cultures maintain varied interpretations of the concept of time which may affect their interaction with the healthcare system. Those from a Chinese or European heritage are more oriented to the past and to traditional values (Galanti, 2004). Middle class Anglos may be more concerned with the future which they exhibit by utilizing preventive care measures such as immunizations and regular checkups (Spector, 2004). Many cultures, such as African-Americans, are oriented to the present rather than the future (Eshiett & Parry, 2003). EMS providers often become frustrated with patients who, because they are not oriented to the future, miss clinic appointments, dialysis treatments, and fail to obtain prenatal and early medical care when symptoms first occur. Often patients summon EMS weeks after the onset of symptoms at the point where they have become unbearable, seemingly always at three o'clock in the morning. Poor and homeless populations are also generally more oriented to the present, as many have primary concerns of just surviving each day. Many are not compliant with medicines or follow-up care. With the inability to perceive the future, patients may not take their seizure or hypertension medications as prescribed because they feel fine on that particular day. Tuberculosis patients may not continue their antibiotic therapy because their symptoms have subsided. When interviewing a patient who is present-oriented, the EMT and paramedic must keep in mind that the patient may be unclear exactly when symptoms of a condition began or the time of their last dose of medicine.

Response to pain presents a challenging aspect to patient care. Individuals in some cultures remain stoic, even in the presence of severe pain, while others wail when slightly uncomfortable. In many Asian and Northern European cultures (Galanti, 2004), outward expression of pain designates shame or weakness. On the other hand, emotional expression of pain is accepted and expected in African-American, Hispanic, Jewish, Middle Eastern and Mediterranean cultures, especially during childbirth (Galanti). Unfortunately, the variation in expressing pain can prove difficult for the EMS provider who is attempting to assess and manage pain with analgesics. While the 1-10 pain scale is useful for gauging pain relief for a single patient, it is not useful for comparing pain intensity between different individuals.

Poverty is the culture most seen in EMS. Poverty drives health disparities more than any other factor and is associated with lack of information and resources,

substandard living conditions, increased risk-taking and poor lifestyle, lack of knowledge to cope with life's challenges, and diminished access to health care (Freeman, 2004). Currently, 12 percent of the U.S. population lives in poverty, and 15 percent lacks health insurance, with more ethnicities disproportionately poor (Freeman). Many of the challenging patients EMS providers encounter are members of the culture of poverty. Poor individuals have been viewed as ignorant, undereducated, uncaring and incompetent, but should be treated with the same dignity that all individuals expect and deserve. Poverty exists among myriad elements that complicate health issues that cannot be resolved solely by EMS providers. Poverty is a multifaceted condition which will require extensive governmental and societal changes beyond the scope of the short-term medical care provided by the emergency medical services. Patients in poverty suffer the same diseases as other patients, though their condition is usually encountered in more advanced stages or with combinations of disease processes, as they have not received preventive care or early diagnosis (Benson, 2000).

The homeless population exemplifies the extreme in the culture of poverty, and suffers the same disease complexities. Both poor and homeless people generally function in the present in a crisis mode. Acquiring food and shelter, rather than health care, are their first priorities, and filling prescriptions becomes secondary to accessing food. When disease reaches a crisis state, EMS is summoned.

Many poor and homeless have learned to manipulate the healthcare system to ensure their own survival, and they use EMS to help negotiate the system. Unfortunately, patient education by EMS regarding preventive care, the importance of proper hygiene, compliance with prescription medicines and avoidance of harmful substances such as alcohol, will have little influence on these groups of individuals. Barriers may include an emphasis upon the present, poor life-coping skills, and often a bleak future outlook. Patients who do not have sophisticated skills to address their problems effectively or competently often do not address them at all and counter or anesthetize their stress by smoking, drinking or using substances. Unfortunately, this behavior only perpetuates the culture of poverty and/or homelessness, and proves frustrating to EMS providers who see simple solutions these patients do not. Assisting these patients in their daily chore of maintaining health for survival rather than attempting to teach them middle class interpersonal skills (Benson, 2000) should be the main emphasis of EMS. Inappropriate interpersonal exchanges by EMS providers exacerbate the culture conflict and language barrier, especially if EMS is the first and/or only contact that these individuals have with the American medical system.

Cultural competency refers to possessing knowledge of, awareness and respect for other cultures and ethnic groups (Juckett, 2005). Generalizations about a group refer to the awareness of cultural norms and serve as a starting point for the understanding of a group, keeping in mind that education, nationality, faith, socioeconomic status and acculturization influence individuals greatly (Juckett). Stereotyping, or assuming that every member of a culture or group believes, acts, and thinks alike, can result in negative community relations as well as poor patient care. Ethnocentrism, the belief that one's own culture is superior to others, can provide a barrier for optimum patient care in the emergency medical services. Assuming a patient has the same accessibility to resources and healthcare can blind the EMT or paramedic to the fact that unhealthy patient decisions are often made from lack of choice, not ignorance (Rosenthal, 2006).

Perhaps a more culturally sensitive approach to the Hispanic family in the opening scenario would have included an acknowledgement of the parents' distress

and fear, and an attempt to establish confianza (trust), with an expression of concern. Perhaps better communication and cultural knowledge would have prevented the mistrust and anger experienced by the family members after their son's death.

Emergency medical services plays a key role as the gateway for health care for many individuals, and can set the tone for the entire healthcare system for culturally competent medical care.

References

Benson, D.S. (2000). Providing health care to human beings trapped in the poverty culture: Reconciling the inner self with the business of health care. *Physician Executive*, 26(2), 28-32.

Eshiett, M. U-A., & Parry, E.H.O. (2003). Migrants and health: A cultural dilemma. *Clinical Medicine*, 3(3), 229-231.

Freeman, H.P. (2004). Poverty, culture, and social injustice: Determinants of cancer disparities. *A Cancer Journal for Clinicians*, 54, 72-77.

Frey, W.H. (1999). The United States population: Where the new immigrants are. U.S. Department of State. Retrieved May 15, 2007, from http://usinfo.state.gov/journals/itsv/0699/ijse/frey.htm

Galanti, G-A. (2004). Caring for patients of different cultures (3rd ed.). Philadelphia: University of Pennsylvania Press.

Ikeda, J., & Wright, J. (1998). Pediatrics in a culturally diverse society. *Pediatric Basics*, 85, 12-25.

Institute of Medicine. (2002). Unequal treatment: What healthcare providers need to know about racial and ethnic disparities in health-care. National Academy of Sciences. Retrieved May 15, 2007, from http://www.iom.edu/

Juckett, G. (2005). Cross-cultural medicine. *American Family Physician*, 72(11), 2267-2274.

Rosenthal, M.S. (2006). Cultural competency. *JAMA*, 296(1), 23-24.

Spector, R.E. (2004). Cultural diversity in health and illness (6th ed.). Upper Saddle River, NJ: Pearson Prentice Hall.

Sung, Chen-Li. (1999). Asian patients' distrust of Western medical care: One perspective. *The Mount Sinai Journal of Medicine*, 66(4), 259-261.

Thomas, V.N., Saleem, T., & Abraham, R. (2005). Barriers to effective uptake of cancer screening among black and minority ethnic groups. *International Journal of Palliative Nursing*, 11(11), 562-571.

United States Census Bureau. (2005). Texas becomes nation's newest "majority-minority" state. Retrieved May 15, 2007, from http://www.census.gov/Press-Release/www.releases/archives/population/005514.html

United States Census Bureau. (2004). U.S. interim projections by age, sex, race, and Hispanic origin. Retrieved May 15, 2007, at http://www.census.gov/ipc/www.usinterimproj/

Vivian, C., & Dundes, L. (2004). The crossroads of culture and health among the Roma (Gypsies). *Journal of Nursing Scholarship*, 36(1), 86-91.